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CHALENG 2004 Survey: VA Black Hills HCS (VAMC Fort Meade - 568 and VAMC Hot Springs - 568A4)

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **100**

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

100 (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	75	0
Transitional Housing Beds	37	0
Permanent Housing Beds	25	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Extra veteran beds at RC Mission.
Transitional living facility	Eight-bed transitional house (on grounds of VAMC Hot Springs) will be completed in early 2005. New transitional housing for PTSD patients in Pine Ridge.
Drop-in Center or Day Program	New drop-in Center breaking ground in Pine Ridge. Rapid City VAMC Clinic will expand.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 15   **Non-VA staff Participants: 73%**
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	2.07	8%	2.77	10
2	Long-term, permanent housing	2.21	21%	2.25	1
3	Child care	2.21	0%	2.39	3
4	Halfway house or transitional living facility	2.23	46%	2.76	8
5	Dental care	2.29	8%	2.34	2
6	Help with transportation	2.36	8%	2.82	11
7	Eye care	2.5	0%	2.65	5
8	Glasses	2.5	0%	2.67	6
9	Education	2.5	0%	2.88	13
10	Help with medication	2.64	23%	3.18	24
11	Help managing money	2.64	0%	2.71	7
12	AIDS/HIV testing/counseling	2.79	0%	3.38	30
13	TB treatment	2.86	0%	3.45	33
14	SSI/SSD process	2.86	0%	3.02	19
15	Job training	2.86	0%	2.88	14
16	Legal assistance	2.86	0%	2.61	4
17	Discharge upgrade	2.91	0%	2.90	15
18	Welfare payments	2.93	0%	2.97	16
19	Treatment for dual diagnosis	3	0%	3.01	18
20	Guardianship (financial)	3	0%	2.76	9
21	Help with finding a job or getting employment	3	8%	3.00	17
22	Personal hygiene (shower, haircut, etc.)	3.07	0%	3.21	26
23	Detoxification from substances	3.07	0%	3.11	22
24	Women's health care	3.07	0%	3.09	21
25	Hepatitis C testing	3.07	0%	3.41	32
26	Help getting needed documents or identification	3.07	0%	3.16	23
27	TB testing	3.14	0%	3.58	36
28	VA disability/pension	3.25	0%	3.33	29
29	Emergency (immediate) shelter	3.36	31%	3.04	20
30	Treatment for substance abuse	3.36	0%	3.30	28
31	Family counseling	3.36	0%	2.85	12
32	Services for emotional or psychiatric problems	3.43	0%	3.20	25
33	Spiritual	3.64	23%	3.30	27
34	Clothing	3.79	8%	3.40	31
35	Food	3.93	23%	3.56	35
36	Medical services	4.15	0%	3.55	34

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.79	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.29	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.79	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.86	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.57	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.64	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.62	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.85	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.09	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.73	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.18	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.45	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.8	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.09	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.18	1.84

CHALENG 2004 Survey: VAH&ROC Sioux Falls, SD - 438

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 30

2. Point-in-time estimate of Veterans who are Chronically Homeless: 5

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

30 (point-in-time estimate of homeless veterans in service area)
X 20% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 77%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 5** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	305	30
Permanent Housing Beds	0	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	When new homeless coordinator is hired that person will work with homeless coalition to determine additional beds needed in the community and explore funding sources that may be available. Also need to determine if increasing transitional beds would help -- emergency beds are now being used as transitional beds.
Transitional living facility	Work with homeless coalition to explore need for additional beds.
Drop-in Center or Day Program	Work with homeless coalition to determine needs and explore funding sources that may be available.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 7   **Non-VA staff Participants: 71%**
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Halfway house or transitional living facility	2.17	25%	2.76	8
2	Legal assistance	2.2	0%	2.61	4
3	Long-term, permanent housing	2.33	25%	2.25	1
4	SSI/SSD process	2.4	25%	3.02	19
5	Child care	2.4	0%	2.39	3
6	Drop-in center or day program	2.5	0%	2.77	10
7	AIDS/HIV testing/counseling	2.6	0%	3.38	30
8	TB testing	2.6	0%	3.58	36
9	TB treatment	2.6	0%	3.45	33
10	Dental care	2.6	0%	2.34	2
11	Eye care	2.6	0%	2.65	5
12	Help managing money	2.6	0%	2.71	7
13	Help with transportation	2.6	25%	2.82	11
14	Discharge upgrade	2.6	0%	2.90	15
15	Personal hygiene (shower, haircut, etc.)	2.67	0%	3.21	26
16	Hepatitis C testing	2.75	0%	3.41	32
17	Glasses	2.8	0%	2.67	6
18	Guardianship (financial)	2.8	0%	2.76	9
19	Job training	2.8	0%	2.88	14
20	Help with finding a job or getting employment	2.8	25%	3.00	17
21	Detoxification from substances	2.83	0%	3.11	22
22	Help with medication	2.83	0%	3.18	24
23	Emergency (immediate) shelter	3	25%	3.04	20
24	Family counseling	3	0%	2.85	12
25	Clothing	3.17	0%	3.40	31
26	Women's health care	3.17	0%	3.09	21
27	Help getting needed documents or identification	3.2	0%	3.16	23
28	Education	3.2	25%	2.88	13
29	Treatment for substance abuse	3.33	0%	3.30	28
30	Medical services	3.33	0%	3.55	34
31	Food	3.5	25%	3.56	35
32	Services for emotional or psychiatric problems	3.5	0%	3.20	25
33	Treatment for dual diagnosis	3.5	0%	3.01	18
34	Welfare payments	3.6	0%	2.97	16
35	Spiritual	3.6	0%	3.30	27
36	VA disability/pension	3.8	0%	3.33	29

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.8	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.8	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.2	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.2	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.2	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.2	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.6	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.4	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.4	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.4	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.4	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.8	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.4	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.4	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.6	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.4	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.8	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

CHALENG 2004 Survey: VAM&ROC Fargo, ND - 437

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **1100**

2. Point-in-time estimate of Veterans who are Chronically Homeless: 366

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1100** (point-in-time estimate of homeless veterans in service area)
> **X 41%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 81%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 366** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	679	117
Transitional Housing Beds	282	100
Permanent Housing Beds	262	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue encouragement for eligible community activities to apply for available funding. Ongoing collaboration with local housing authorities for increased scattered sites/Shelter Plus Care and Section 8 vouchers.
Transitional living facility	Establish VA contract with Share House in Fargo, ND. Continue collaboration and involvement with administrative and program requirements for approved 48-bed Grant and Per Diem Project.
Immediate shelter	Ongoing encouragement/collaboration with local shelters to apply for available expansion funding. Involvement with community leaders and state/local homeless coalitions to determine possibility/feasibility of creating additional immediate shelter along I-94 corridor.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 42   Non-VA staff Participants: 85%
Homeless/Formerly Homeless: 2%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.22	39%	2.25	1
2	Drop-in center or day program	2.23	0%	2.77	10
3	Dental care	2.23	11%	2.34	2
4	Child care	2.42	3%	2.39	3
5	Glasses	2.64	0%	2.67	6
6	Eye care	2.67	0%	2.65	5
7	Halfway house or transitional living facility	2.68	39%	2.76	8
8	Help managing money	2.79	0%	2.71	7
9	Legal assistance	2.89	0%	2.61	4
10	Detoxification from substances	2.93	6%	3.11	22
11	Guardianship (financial)	2.95	3%	2.76	9
12	Job training	2.95	0%	2.88	14
13	Family counseling	2.98	0%	2.85	12
14	Education	3.03	3%	2.88	13
15	Treatment for dual diagnosis	3.08	6%	3.01	18
16	Help with transportation	3.1	0%	2.82	11
17	SSI/SSD process	3.13	0%	3.02	19
18	Emergency (immediate) shelter	3.17	31%	3.04	20
19	Services for emotional or psychiatric problems	3.2	6%	3.20	25
20	Help with medication	3.2	3%	3.18	24
21	AIDS/HIV testing/counseling	3.2	0%	3.38	30
22	Help getting needed documents or identification	3.21	0%	3.16	23
23	Treatment for substance abuse	3.24	6%	3.30	28
24	Help with finding a job or getting employment	3.24	3%	3.00	17
25	Welfare payments	3.26	0%	2.97	16
26	Discharge upgrade	3.34	0%	2.90	15
27	TB treatment	3.39	0%	3.45	33
28	Personal hygiene (shower, haircut, etc.)	3.4	3%	3.21	26
29	Spiritual	3.42	6%	3.30	27
30	Women's health care	3.44	0%	3.09	21
31	TB testing	3.56	0%	3.58	36
32	Hepatitis C testing	3.59	3%	3.41	32
33	Clothing	3.61	6%	3.40	31
34	Medical services	3.63	8%	3.55	34
35	VA disability/pension	3.64	8%	3.33	29
36	Food	3.8	8%	3.56	35

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.6	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.41	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.34	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.36	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.26	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.97	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.84	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.58	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.86	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.03	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.58	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.67	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.11	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.56	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.64	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.47	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.64	1.84

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CHALENG 2004 Survey: VAMC Minneapolis, MN - 618, and Superior, WI

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **100**

2. Point-in-time estimate of Veterans who are Chronically Homeless: 12

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

100 (point-in-time estimate of homeless veterans in service area)
X 13% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 94%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 12** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	940	100
Transitional Housing Beds	144	15
Permanent Housing Beds	212	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	On-going support for 220-bed SRO on VA property. Attend St. Paul area Coalition for Homeless & provide support for housing projects. VA Healthcare for Homeless Veterans provides assistance to homeless veterans on how to access and apply for housing.
Transitional living facility	VA Healthcare for Homeless Veterans staff work with homeless vets to make application and promote care and treatment that will increase likely successful admission and stay. Support VA Grant and Per Diem program receiving money for transitional housing.
Immediate shelter	VA Healthcare for Homeless Veterans staff attend Shelter Provider Action Association and provide support and planning/assessment of shelter needs and accomplishments.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 48   Non-VA staff Participants: 81%
Homeless/Formerly Homeless: 8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.02	52%	2.25	1
2	Child care	2.32	0%	2.39	3
3	Dental care	2.35	9%	2.34	2
4	Help managing money	2.45	4%	2.71	7
5	Halfway house or transitional living facility	2.6	28%	2.76	8
6	Eye care	2.61	0%	2.65	5
7	Job training	2.62	2%	2.88	14
8	Help with transportation	2.62	7%	2.82	11
9	Glasses	2.63	0%	2.67	6
10	Help with finding a job or getting employment	2.68	9%	3.00	17
11	Legal assistance	2.69	2%	2.61	4
12	Education	2.74	2%	2.88	13
13	Family counseling	2.81	2%	2.85	12
14	Guardianship (financial)	2.82	4%	2.76	9
15	SSI/SSD process	2.91	0%	3.02	19
16	Discharge upgrade	2.93	0%	2.90	15
17	Treatment for dual diagnosis	2.96	9%	3.01	18
18	Help with medication	2.96	9%	3.18	24
19	Emergency (immediate) shelter	3.02	15%	3.04	20
20	Drop-in center or day program	3.02	2%	2.77	10
21	Help getting needed documents or identification	3.02	0%	3.16	23
22	Services for emotional or psychiatric problems	3.11	4%	3.20	25
23	Spiritual	3.11	0%	3.30	27
24	Welfare payments	3.15	2%	2.97	16
25	Personal hygiene (shower, haircut, etc.)	3.19	0%	3.21	26
26	Women's health care	3.2	0%	3.09	21
27	Clothing	3.3	2%	3.40	31
28	AIDS/HIV testing/counseling	3.46	0%	3.38	30
29	TB treatment	3.5	0%	3.45	33
30	VA disability/pension	3.51	2%	3.33	29
31	Detoxification from substances	3.53	7%	3.11	22
32	Medical services	3.54	7%	3.55	34
33	Hepatitis C testing	3.6	0%	3.41	32
34	Food	3.61	2%	3.56	35
35	TB testing	3.63	2%	3.58	36
36	Treatment for substance abuse	3.7	7%	3.30	28

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.54	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.31	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.96	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.21	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.96	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.15	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.81	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.53	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.51	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.15	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.51	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.79	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.58	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.7	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.24	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.61	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.62	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.81	1.84

CHALENG 2004 Survey: VAMC St. Cloud, MN - 656

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **30**

2. Point-in-time estimate of Veterans who
are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

30 (point-in-time estimate of homeless veterans in service area)
X <DATA NOT AVAILABLE>% (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	77	30
Transitional Housing Beds	248	40
Permanent Housing Beds	258	60

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Sixty-unit single adult permanent housing project to be built on VA grounds. Memorandum of understanding is signed. Groundbreaking to commence in October 2004. Support the efforts of HRA to work cooperatively with contractors to build more affordable, permanent housing.
Transitional living facility	Support Salvation Army's plan to build 15 units of transitional housing and work with them to obtain VA Grant and Per Diem funding. Research possibility of additional transitional housing on VA ground or development of cooperative working relationships with community service providers.
Immediate shelter	Support efforts of Salvation Army to build 90 new shelter beds be fall-back site should they not get KRAC funding to build elsewhere. Continue to be working member of the local homeless concerns group and Continuum of Care.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 12   **Non-VA staff Participants: 92%**
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.83	50%	2.25	1
2	Dental care	2.09	17%	2.34	2
3	Help with finding a job or getting employment	2.55	0%	3.00	17
4	Child care	2.55	0%	2.39	3
5	Emergency (immediate) shelter	2.58	33%	3.04	20
6	Halfway house or transitional living facility	2.58	17%	2.76	8
7	Help managing money	2.58	25%	2.71	7
8	SSI/SSD process	2.64	0%	3.02	19
9	Family counseling	2.73	0%	2.85	12
10	Drop-in center or day program	2.73	0%	2.77	10
11	Guardianship (financial)	2.73	0%	2.76	9
12	Legal assistance	2.73	8%	2.61	4
13	Help with transportation	2.8	0%	2.82	11
14	Personal hygiene (shower, haircut, etc.)	2.82	0%	3.21	26
15	AIDS/HIV testing/counseling	2.91	0%	3.38	30
16	Education	2.91	8%	2.88	13
17	Job training	3	0%	2.88	14
18	Help getting needed documents or identification	3	0%	3.16	23
19	Treatment for dual diagnosis	3.09	0%	3.01	18
20	Help with medication	3.09	0%	3.18	24
21	TB treatment	3.09	0%	3.45	33
22	Treatment for substance abuse	3.27	8%	3.30	28
23	Medical services	3.27	0%	3.55	34
24	Eye care	3.27	0%	2.65	5
25	Glasses	3.27	0%	2.67	6
26	Services for emotional or psychiatric problems	3.36	0%	3.20	25
27	Women's health care	3.36	0%	3.09	21
28	TB testing	3.36	0%	3.58	36
29	Discharge upgrade	3.36	0%	2.90	15
30	Spiritual	3.36	17%	3.30	27
31	Clothing	3.45	8%	3.40	31
32	Detoxification from substances	3.45	0%	3.11	22
33	Welfare payments	3.45	0%	2.97	16
34	Hepatitis C testing	3.5	0%	3.41	32
35	Food	3.64	8%	3.56	35
36	VA disability/pension	3.64	0%	3.33	29

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.58	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.92	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.08	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.17	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.55	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.58	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.58	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.33	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.25	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.25	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.58	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.25	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.58	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.58	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.08	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.42	1.84

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CHALENG 2004 Survey: VA Central Iowa HCS (VAMC Knoxville - 555A4)

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **12**

**2. Point-in-time estimate of Veterans who
are Chronically Homeless: 3**

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

12 (point-in-time estimate of homeless veterans in service area)
X 33% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 67%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 3** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	20	0
Transitional Housing Beds	69	10
Permanent Housing Beds	10	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	The identified needs were all over the board. Two persons at our CHALENG meeting said emergency shelter was a priority, but in past meetings, community staff said this is not a big issue.
Treatment for Dual Diagnosis	Continue to use the VA Des Moines dual diagnosis program. That is the only service in the area.
Help with Transportation	Contact VSOs to see if they can assist with transportation on a voluntary basis.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 8   **Non-VA staff Participants: 75%**
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	2	0%	2.77	10
2	Guardianship (financial)	2	0%	2.76	9
3	Help managing money	2	0%	2.71	7
4	Help with finding a job or getting employment	2	13%	3.00	17
5	Job training	2.13	13%	2.88	14
6	Education	2.13	0%	2.88	13
7	Help getting needed documents or identification	2.25	13%	3.16	23
8	Child care	2.25	0%	2.39	3
9	Long-term, permanent housing	2.38	13%	2.25	1
10	AIDS/HIV testing/counseling	2.38	0%	3.38	30
11	Glasses	2.38	0%	2.67	6
12	Legal assistance	2.38	0%	2.61	4
13	Dental care	2.5	13%	2.34	2
14	Eye care	2.5	0%	2.65	5
15	Help with transportation	2.5	0%	2.82	11
16	Personal hygiene (shower, haircut, etc.)	2.75	0%	3.21	26
17	Halfway house or transitional living facility	2.75	25%	2.76	8
18	TB testing	2.75	0%	3.58	36
19	TB treatment	2.75	0%	3.45	33
20	Hepatitis C testing	2.75	0%	3.41	32
21	Spiritual	2.75	0%	3.30	27
22	Family counseling	2.88	0%	2.85	12
23	Detoxification from substances	3	13%	3.11	22
24	Treatment for dual diagnosis	3	0%	3.01	18
25	Medical services	3	25%	3.55	34
26	VA disability/pension	3	0%	3.33	29
27	SSI/SSD process	3	0%	3.02	19
28	Treatment for substance abuse	3.13	13%	3.30	28
29	Women's health care	3.13	0%	3.09	21
30	Services for emotional or psychiatric problems	3.38	13%	3.20	25
31	Help with medication	3.38	0%	3.18	24
32	Welfare payments	3.63	0%	2.97	16
33	Clothing	3.75	0%	3.40	31
34	Emergency (immediate) shelter	3.75	38%	3.04	20
35	Discharge upgrade	3.75	0%	2.90	15
36	Food	4.13	13%	3.56	35

* % of Participants who identified this need as one of the top three they would like to work
on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.88	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.63	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.88	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.63	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.5	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.5	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.33	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.83	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.33	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.83	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.5	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.83	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.33	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1	1.84

CHALENG 2004 Survey: VA Central Iowa HCS (VAMC Des Moines - 555)

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **1000**

2. Point-in-time estimate of Veterans who are Chronically Homeless: 222

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

1000 (point-in-time estimate of homeless veterans in service area)
X 33% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 67%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 222** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	595	25
Transitional Housing Beds	359	11
Permanent Housing Beds	100	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Attempt to find more immediate shelter (emergency) by finding funding resources.
Transitional living facility	Find and assist community agencies to apply for VA Grant and Per Diem funds to house veterans.
Long-term, permanent housing	Attempt to find apartments and houses for veterans who are homeless.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 17   **Non-VA staff Participants: 63%**
Homeless/Formerly Homeless: 35%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.18	21%	2.34	2
2	Long-term, permanent housing	2.24	0%	2.25	1
3	Help managing money	2.44	0%	2.71	7
4	Child care	2.47	7%	2.39	3
5	Help with transportation	2.53	0%	2.82	11
6	Legal assistance	2.59	0%	2.61	4
7	Glasses	2.65	7%	2.67	6
8	Guardianship (financial)	2.65	0%	2.76	9
9	Job training	2.65	14%	2.88	14
10	Family counseling	2.71	0%	2.85	12
11	Eye care	2.71	7%	2.65	5
12	Discharge upgrade	2.71	0%	2.90	15
13	Detoxification from substances	2.76	0%	3.11	22
14	Welfare payments	2.76	7%	2.97	16
15	Women's health care	2.82	0%	3.09	21
16	Education	2.82	7%	2.88	13
17	Drop-in center or day program	2.88	0%	2.77	10
18	VA disability/pension	2.88	29%	3.33	29
19	Services for emotional or psychiatric problems	2.94	0%	3.20	25
20	Spiritual	2.94	0%	3.30	27
21	Halfway house or transitional living facility	3	29%	2.76	8
22	Help with finding a job or getting employment	3	7%	3.00	17
23	Treatment for substance abuse	3.06	0%	3.30	28
24	TB treatment	3.06	0%	3.45	33
25	Help getting needed documents or identification	3.06	0%	3.16	23
26	Treatment for dual diagnosis	3.12	0%	3.01	18
27	Help with medication	3.12	0%	3.18	24
28	AIDS/HIV testing/counseling	3.12	0%	3.38	30
29	SSI/SSD process	3.19	14%	3.02	19
30	TB testing	3.24	0%	3.58	36
31	Hepatitis C testing	3.35	0%	3.41	32
32	Personal hygiene (shower, haircut, etc.)	3.47	0%	3.21	26
33	Medical services	3.53	13%	3.55	34
34	Clothing	3.59	0%	3.40	31
35	Food	3.88	14%	3.56	35
36	Emergency (immediate) shelter	4	29%	3.04	20

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.59	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.76	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.38	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.88	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.56	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.91	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.27	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.27	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.1	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.45	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.36	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.55	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.64	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.7	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.6	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.5	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.6	1.84

CHALENG 2004 Survey: VA HCS (VAMC Grand Island - 597A4 and VAMC Lincoln - 597)

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **120**

2. Point-in-time estimate of Veterans who are Chronically Homeless: 31

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

120 (point-in-time estimate of homeless veterans in service area)
X 34% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 77%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 31** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	0
Transitional Housing Beds	100	50
Permanent Housing Beds	30	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Dental Care	Develop task force on healthcare for the homeless. Establish co-payment assistance fund for veterans not eligible for VA dental care. Increase drop-in services and extend service hours at identified community healthcare providers.
Help with finding a job or getting employment	Develop stronger relationship between homeless providers and business/corporate sector, including: Downtown Lincoln Association, Lincoln Chamber of Commerce, and Lincoln Independent Business Association. Identify and recruit advocates for homeless issues (employment) among business/corporate sector.
Help with Transportation	Enhance satellite and mobile health clinic services. Provide community support and city government assistance in investigating variety of opportunities related to transportation including federal funding available through Public Service Action, Section 330H.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 19   **Non-VA staff Participants: 95%**
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	1.94	13%	2.77	10
2	Dental care	2.39	0%	2.34	2
3	Long-term, permanent housing	2.44	20%	2.25	1
4	Emergency (immediate) shelter	2.5	47%	3.04	20
5	Help with medication	2.53	27%	3.18	24
6	Halfway house or transitional living facility	2.67	27%	2.76	8
7	Eye care	2.67	0%	2.65	5
8	Child care	2.71	0%	2.39	3
9	Glasses	2.72	0%	2.67	6
10	Help with transportation	2.72	20%	2.82	11
11	TB treatment	2.73	0%	3.45	33
12	Personal hygiene (shower, haircut, etc.)	2.78	0%	3.21	26
13	Treatment for dual diagnosis	2.78	0%	3.01	18
14	Hepatitis C testing	2.82	0%	3.41	32
15	Education	2.82	0%	2.88	13
16	Guardianship (financial)	2.88	0%	2.76	9
17	Job training	2.88	13%	2.88	14
18	Legal assistance	2.88	0%	2.61	4
19	Services for emotional or psychiatric problems	2.89	0%	3.20	25
20	Treatment for substance abuse	2.94	13%	3.30	28
21	Help managing money	2.94	0%	2.71	7
22	Detoxification from substances	3	7%	3.11	22
23	TB testing	3	0%	3.58	36
24	Discharge upgrade	3	0%	2.90	15
25	Family counseling	3.06	0%	2.85	12
26	Help getting needed documents or identification	3.06	0%	3.16	23
27	Clothing	3.11	0%	3.40	31
28	Women's health care	3.11	0%	3.09	21
29	Welfare payments	3.12	0%	2.97	16
30	SSI/SSD process	3.12	0%	3.02	19
31	Help with finding a job or getting employment	3.12	0%	3.00	17
32	AIDS/HIV testing/counseling	3.13	0%	3.38	30
33	Medical services	3.17	7%	3.55	34
34	Food	3.22	7%	3.56	35
35	VA disability/pension	3.41	0%	3.33	29
36	Spiritual	3.44	0%	3.30	27

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.26	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.26	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.61	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.94	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.39	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.67	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.17	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.17	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.33	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.39	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.72	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.33	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.22	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.56	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.39	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.22	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.28	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.28	1.84

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CHALENG 2004 Survey: VA HCS (VAMC Omaha - 636)

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 325

2. Point-in-time estimate of Veterans who are Chronically Homeless: 147

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

325 (point-in-time estimate of homeless veterans in service area)
X 57% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 79%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 147** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	480	150
Transitional Housing Beds	440	200
Permanent Housing Beds	0	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Francis House is currently building an additional 200 beds and is willing to designate veteran beds from VA Per Diem monies. MHM's is planning on building 50 beds with 25 for shelter. They would also like to designate veteran beds.
Transitional living facility	Two agencies are building new facilities with transitional beds.
Long-term, permanent housing	POC has a working relationship with local housing authority but no direct access to Section 8 certificates.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 7   **Non-VA staff Participants**: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	1.57	14%	2.77	10
2	Long-term, permanent housing	2.14	14%	2.25	1
3	Treatment for dual diagnosis	2.43	29%	3.01	18
4	Dental care	2.43	0%	2.34	2
5	Halfway house or transitional living facility	2.57	57%	2.76	8
6	Glasses	2.57	0%	2.67	6
7	Help managing money	2.57	0%	2.71	7
8	Guardianship (financial)	2.67	0%	2.76	9
9	Job training	2.71	0%	2.88	14
10	Women's health care	2.83	0%	3.09	21
11	Eye care	2.86	0%	2.65	5
12	SSI/SSD process	3	0%	3.02	19
13	Help with finding a job or getting employment	3	29%	3.00	17
14	Help getting needed documents or identification	3	0%	3.16	23
15	Child care	3	0%	2.39	3
16	Services for emotional or psychiatric problems	3.14	0%	3.20	25
17	Family counseling	3.14	0%	2.85	12
18	Help with transportation	3.14	0%	2.82	11
19	Education	3.14	0%	2.88	13
20	VA disability/pension	3.17	0%	3.33	29
21	Welfare payments	3.17	0%	2.97	16
22	Emergency (immediate) shelter	3.29	57%	3.04	20
23	Detoxification from substances	3.29	0%	3.11	22
24	Help with medication	3.29	0%	3.18	24
25	Treatment for substance abuse	3.43	0%	3.30	28
26	Medical services	3.43	0%	3.55	34
27	AIDS/HIV testing/counseling	3.57	0%	3.38	30
28	TB treatment	3.57	0%	3.45	33
29	Hepatitis C testing	3.57	0%	3.41	32
30	Legal assistance	3.71	0%	2.61	4
31	Spiritual	3.71	0%	3.30	27
32	Discharge upgrade	3.75	0%	2.90	15
33	Personal hygiene (shower, haircut, etc.)	3.86	0%	3.21	26
34	TB testing	4	0%	3.58	36
35	Clothing	4.14	0%	3.40	31
36	Food	4.29	0%	3.56	35

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.86	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.71	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.86	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.29	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.57	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.86	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.14	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.29	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.71	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.29	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.71	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.43	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.29	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.29	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.43	1.84

CHALENG 2004 Survey: VAMC Iowa City, IA - 584

VISN 23

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): **400**

2. Point-in-time estimate of Veterans who are Chronically Homeless: 34

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.   Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

400 (point-in-time estimate of homeless veterans in service area)
X 15% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 57%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 34** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	335	80
Transitional Housing Beds	204	170
Permanent Housing Beds	587	300

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Our LHBC's have/are still in the process of establishing Community Development Block Grant (CDBG) funds to assist the homeless with security deposits. Also, the STAR program is working on a security deposit system.
Immediate shelter	Our LHCB's have/are going to be working with the CRC's (Religious Communities) to set up overflow shelter space in churches for the winter months.
Help with finding a job or getting employment	Meetings have been set up to establish CWT sites in our coverage area.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 21   **Non-VA staff Participants: 90%**
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.14	24%	2.25	1
2	Drop-in center or day program	2.29	5%	2.77	10
3	Dental care	2.38	10%	2.34	2
4	Eye care	2.57	5%	2.65	5
5	Glasses	2.57	0%	2.67	6
6	Child care	2.67	5%	2.39	3
7	Help managing money	2.71	5%	2.71	7
8	Treatment for dual diagnosis	2.76	5%	3.01	18
9	Halfway house or transitional living facility	2.86	14%	2.76	8
10	Emergency (immediate) shelter	2.95	24%	3.04	20
11	Legal assistance	2.95	5%	2.61	4
12	Women's health care	3	5%	3.09	21
13	Help with transportation	3.05	0%	2.82	11
14	Family counseling	3.1	0%	2.85	12
15	TB treatment	3.1	0%	3.45	33
16	Personal hygiene (shower, haircut, etc.)	3.14	0%	3.21	26
17	AIDS/HIV testing/counseling	3.14	0%	3.38	30
18	TB testing	3.14	0%	3.58	36
19	Education	3.14	5%	2.88	13
20	Guardianship (financial)	3.19	0%	2.76	9
21	Detoxification from substances	3.24	0%	3.11	22
22	Job training	3.24	0%	2.88	14
23	Services for emotional or psychiatric problems	3.29	19%	3.20	25
24	Hepatitis C testing	3.38	5%	3.41	32
25	SSI/SSD process	3.38	5%	3.02	19
26	Discharge upgrade	3.4	0%	2.90	15
27	Treatment for substance abuse	3.43	0%	3.30	28
28	Welfare payments	3.52	0%	2.97	16
29	Help with finding a job or getting employment	3.52	19%	3.00	17
30	Clothing	3.57	5%	3.40	31
31	Help with medication	3.62	5%	3.18	24
32	VA disability/pension	3.62	10%	3.33	29
33	Help getting needed documents or identification	3.62	5%	3.16	23
34	Spiritual	3.76	10%	3.30	27
35	Food	3.86	14%	3.56	35
36	Medical services	3.86	0%	3.55	34

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.48	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.48	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.24	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.76	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.95	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.81	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.57	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.59	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.94	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.28	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.56	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.39	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.06	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.88	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.61	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.78	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.78	1.84